LINDA LINGLE
GOVERNOR OF HAWAII

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DIRECTOR OF HEALTH

STATE OF HAWAII
DEPARTMENT OF HEALTH
FAMILY HEALTH SERVICES DIVISION
MATERNAL AND CHILD HEALTH BRANCH
WOMEN'S HEALTH SECTION - FAMILY PLANNING PROGRAM
741-A SUNSET AVENUE, ROOM 100
HONOLULU, HAWAII 96816

In reply, please refer to:
File:

November 9, 2004

To: Title X Family Planning Services Applicants

From: Karen Mak, Program Manager
Family Panning Program

Subject: **Addendum 1 to RFP Number HTH 550-5**

The following statement shall be replaced in Section 2, page 2-9, item 4, paragraph two:

Delete statement

Outputs will be collected on the CVR which is an individual client visit record documented for each FP visit. (Attachment E)

Replacement

The annual number of family planning clients and family planning visits will be projected on Table B – Output Measures. (Attachment E)

The following statement and attachment shall be added in Section 5, Attachment E, Table B – Output Measures:

Delete Statements

A. The total number of unduplicated uninsured clients.
B. The total number of uninsured client visits.

Replacements

A. The agency's total number of unduplicated family planning clients.
B. The agency's total number of family planning client visits.

Attachment M shall be added in Section 2, page 2-10, item 7b:

Delete statement

An individual client visit record (CVR) will be completed for all FP client visits made to the agency. Family planning client visits include uninsured, QUEST, Medicaid, military, and private pay clients. The CVR data will be inputted into the FP software by the awardee.

Replacement

An individual client visit record (CVR) will be completed for all FP client visits made to the agency. Family planning client visits include uninsured, QUEST, Medicaid, military, and private pay clients. The CVR data will be inputted into the FP software by the awardee. (Attachment M)

The following attachment shall be added to Section 5, Attachments:

Attachment M Client Visit Record (CVR)

The following certification shall be added to Section 5, Attachment A, Proposal Application Checklist, Federal Certifications:

Assurances-Non-Construction Programs

The following statement and attachment shall be added in Section 5, Attachment J, Quarterly Report Form, Declaration :

Delete statement

Declaration: I declare that this report has been examined by me and to the best of knowledge and belief is a true, correct, and complete report, made in food faith, for the period stated.

Replacement

Declaration: I declare that this report has been examined by me and to the best of knowledge and belief is a true, correct, and complete report, made in good faith, for the period stated.

Attachments Added

Attachment E, Table B – Output Measures, revised 11/04
Attachment J, Quarterly Report Form, revised 11/04
Attachment M, Client Visit Record (CVR)

RFP No.: HTH 550-5

ATTACHMENT E

Table B - Output Measures

Program Activity	Baseline FY 2004	Estimated FY 2006	Estimated FY 2007
A. The agency's total number of unduplicated family planning clients.			
B. The agency's total number of family planning client visits.			

(Revised 11/04)

RFP No.: HTH 550-5

ATTACHMENT J

Family Planning Program
Quarterly Report Form

Agency: _____

(circle one) Jan. – March 200___ Apr. – June 200___ July – Sept. 200___ Oct. – Dec. 200___

**** Due the 15th of the following month.****

Screening Activity	Number of Tests
Number of Pap tests with an ASC or higher result *	
Number of Pap tests with a HSIL or higher result *	
** see Exhibit 1. The 2001 Bethesda System (Abridged)*	
Number of HIV – Positive confidential tests	
Number of HIV- Anonymous tests done	

Community Education/Outreach Activities Report	Attached

Declaration: *I declare that this report has been examined by me and to the best of knowledge and belief is a true, correct, and complete report, made in good faith, for the period stated.*

Prepared by: _____ *Date:* _____

Reviewed by: _____ *Date:* _____

Rev. 11/04

RFP No.: HTH 550-5

ATTACHMENT M

Effective Date: 1/1/2005

Client ID (REQUIRED): _____

Family Planning Client Visit Record (CVR) Hawaii Department of Health

Last Name: _____ **First Name:** _____

Age: _____ **Date of Birth:** _____ / _____ / _____ **Sex: F** ___ **M** ___ **Zip Code** _____

Citizen Status: ☐ U.S. Citizen ☐ Immigrant ☐ Refugee ☐ Student Visa ☐ Tourist Visa ☐ Other

Hispanic or Latino Origin: ☐ No ☐ Yes

Ethnicity (select one or more):

- ☐ African American
- ☐ American Indian/Alaskan Native
- ☐ Caucasian/White
- ☐ Chinese
- ☐ Filipino
- ☐ Hawaiian/Part Hawaiian
- ☐ Japanese
- ☐ Korean
- ☐ Marshallese
- ☐ Micronesian
- ☐ Portuguese
- ☐ Puerto Rican/Mexican/Cuban
- ☐ Samoan
- ☐ Vietnamese
- ☐ Other Asian
- ☐ Other Pacific Islander
- ☐ Other _____
- ☐ Unknown/Refused

STAFF TO COMPLETE

Income Level (check one): ☐ 100% and below ☐ 101 - 125% ☐ 126 -150% ☐ 151-175% ☐ 176 - 200% ☐ 201 - 250% ☐ Over 250%

Insurance Status (check one): ☐ Uninsured ☐ Public Health Ins ☐ Private Health Ins ☐ Military Insurance

Limited English Proficiency: ☐ No ☐ Yes

CLINICIAN TO COMPLETE

Date of Visit: _____ / _____ / _____ **Goal for this visit:** ☐ Avoid Pregnancy ☐ Seek Pregnancy

Provider of Service (check one): ☐ NP, CNM, or PA ☐ Physician ☐ RN/LPN ☐ Other Provider

Type of Visit (check one): ☐ Comprehensive Exam ☐ Routine FP Visit ☐ FP Procedure ☐ FP Education

Services this Visit (check all that apply):

- ☐ BP Screening
- ☐ Clinical Breast Exam
- ☐ Pelvic Exam
- ☐ Pap Smear
- ☐ Testicular Exam
- ☐ EC
- ☐ Pregnancy Test
- ☐ FP Ed/Counsel
- ☐ HIV/STD Screening
- ☐ HIV/STD Ed/Counseling
- ☐ STD Treatment
- ☐ HIV Results/Counseling
- ☐ Infertility/Level one
- ☐ Cervical/Diaphragm Fitting
- ☐ IUD Insertion/Removal
- ☐ Implant Insertion/Removal

If Clinical Breast Exam, CBE Result (check one): ☐ WNL ☐ Referred for further evaluation

If Pregnancy Test, Pregnancy Test Result:

- ☐ Negative-Pregnancy Unplanned
- ☐ Negative-Pregnancy Planned
- ☐ Positive - Unplanned-Failed Method
- ☐ Positive - Unplanned-No Method
- ☐ Positive - Planned Pregnancy

If STD Screening, Type of STD tests: ☐ Chlamydia ☐ Gonorrhea ☐ Syphilis ☐ HIV-Confidential

Primary Contraceptive Method at end of visit (check only one - most effective method):

- ☐ Abstinence
- ☐ Cervical Cap/Diaphragm
- ☐ Condoms
- ☐ Contraceptive Sponge
- ☐ Hormonal Implant
- ☐ Hormonal Patch
- ☐ Injections
- ☐ IUD
- ☐ Oral Contraceptive
- ☐ Spermicide (used alone)
- ☐ Vaginal Ring
- ☐ Vasectomy
- ☐ Female Surgical Sterlization
- ☐ Fertility Awareness Method
- ☐ Other Female Method
- ☐ Other Male Method
- ☐ No Method

If Condoms, Type of Condom (choose one): ☐ Male ☐ Male and Spermicide ☐ Female ☐ Female and Spermicide

If Injection, Frequency of Injection (choose one): ☐ 1-Month Injection ☐ 3-Month Injection

If No Method Chosen, Why? (choose one):

- ☐ Currently Pregnant
- ☐ Seeking Pregnancy
- ☐ Relying on Female Partner's Method
- ☐ Relying on Male Partner's Method
- ☐ Other Reason _____

For HIV/STD Prevention: Were condoms given at this visit? ☐ YES ☐ NO